

2015 Residential Life Support Discount

The LPC customer and a licensed attending physician must complete this form. If qualified, the customer will receive a 20% discount on the cost of the first 750 kilowatt hours (kWh) of electricity used each month.

Customers are required to apply for this discount every calendar year.

Customer Information

*To be completed
by LPC customer*

Utility account number _____ (on your City of Longmont utility bill)
Full customer name _____
Service address _____
City _____ Zip Code _____
Patient name _____ Date of birth _____
person requiring medically necessary equipment

Affidavit of Lawful Presence in the United States

*To be completed
by LPC customer*

I, _____, swear and affirm under penalty of perjury under the laws of the State of Colorado that I am (check one):

☐ A United States citizen ☐ A permanent resident of the United States ☐ Lawfully present in the United States

☐ I understand that this sworn statement is required by law because I have applied for a public benefit. I understand that State law requires me to provide proof that I am lawfully present in the United States prior to receipt of this public benefit. I further acknowledge that making a false, fictitious, or fraudulent statement or representation in this sworn affidavit is punishable under the criminal law of Colorado as perjury in the second degree under C.R.S. 18-8-503 and it shall constitute a separate criminal offense each time a public benefit is fraudulently received.

☐ Include a copy of an acceptable form of proof:

- Colorado driver's license
- Colorado identification card
- U.S. military dependent's ID card
- Native American tribal document
- U.S. military card
- U.S. Coast Guard merchant mariner card

My signature certifies all information is true and accurate, that I am lawfully present in the United States and the patient named above lives at this address full time and requires medically necessary equipment, used at the address, which requires electricity to operate.

Signature _____ Date _____

Physician Information

*To be completed by
licensed physician*

Full physician name _____
Office address _____
City _____ ZIP Code _____
Phone number _____ Colorado medical license # _____
Hospital affiliation _____
Type of medically necessary equipment used by patient _____

I certify the patient listed above requires, on an on-going basis, medically necessary equipment, utilized at the patient's home, which uses electricity to operate.

Physician signature _____ Date _____

Return this application or mail to:

Longmont Power & Communications
1100 S. Sherman Street
Longmont, Colorado 80501

Questions: 303.651.8386

Fax: 303.651.8796

Application does not guarantee uninterrupted electric service nor prevent disconnection for non-payment. This discount is provided in accordance with City of Longmont Municipal Code, Title 14, Chapter 14.32, Rates and Regulations governing Electric Service.

Medically necessary equipment for this discount rate is defined as any medical device requiring electricity to operate that is required on an ongoing basis to sustain life of a person residing in a residential dwelling. The term "medically necessary equipment" includes but is not limited to respirators, dialysis machines, suction machines, electric nerve stimulators, pressure pads and pumps and intravenous pumps.

